ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Quarterly Report

January 1, 2002 through March 31, 2002

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Submitted: May 2002

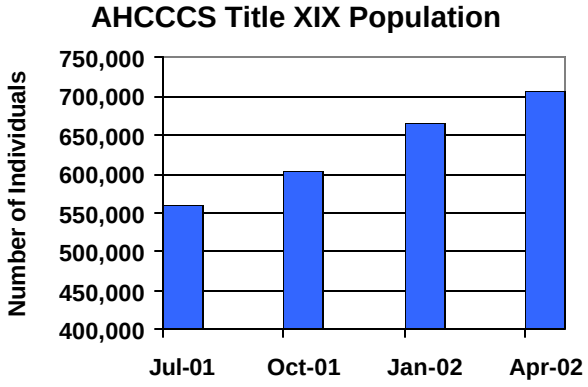
Table of Contents

Executive Summary

Some of the major highlights during this quarter include:

- Arizona's Breast and Cervical Cancer Program began January 1, 2002;
- AHCCCS continued developing a WEB-BASED Verification System;
- Progress continued on launching the Health-e-App program;
- The AHCCCS Community Based Outreach Grant ended this quarter but outreach efforts continue with both new and existing state and local groups;
- Native American enrollment increased from 98,951 to 102,000;
- 100% of claims submitted continued to be processed within seven days or less;
- In February, the Office of Inspector General published and released results of an audit on End Stage Renal Disease Services performed by the AHCCCS Office of Program Integrity (OPI);
- The Physician Fee Schedule was updated; and,
- A streamlined process for eligibility has been developed for patients discharged from the Arizona State Hospital needing acute, behavioral, and long-term care services.

AHCCCS Population



On April 1, 2002, the AHCCCS Title XIX population totaled 706,603 individuals. The end of March marked the 9th consecutive month that AHCCCS experienced an increase in enrollment. This enrollment figure represents a 6.3% increase over last quarter. This number includes 672,815 individuals receiving acute care services, an increase of 41,434 members, and 33,788 members receiving ALTCS services, an increase of 298 members. Also included is 102,000 Native American members, an increase of approximately 4% since last quarter. This is due, in part, to a vigorous outreach effort over the last year that succeeded in reaching a highly remote and distant population.

New Developments

Breast and Cervical Cancer Treatment Program (BCCTP)

Arizona's BCCTP program began January 1, 2002. This program is available to women who are screened and diagnosed as needing treatment for breast and/or cervical cancer by the Well Woman Healthcheck Program (WWHP) administered by the Arizona Department of Health Services (ADHS). WWHP case managers help women complete an application for AHCCCS Health Insurance and forward the application to AHCCCS where the application is screened for

other Medicaid programs prior to being approved for BCCTP. As of March 31, 2002 six women have been approved for medical services via this process, four of them on BCCTP and two who were found to be eligible for other Medicaid programs.

Internet - WEB BASED Verifications

As the AHCCCS population continues to increase, the number of requests for verification of eligibility and enrollment continue to place more demands on the AHCCCS 24-hour Communications Center staff.

Currently, providers can verify member information in one of four ways through use of the Prepaid Medical Management Information System (PMMIS) system:

1. Telephone calls to Customer Service Representatives
   - These calls exceed 125,200 per month.
2. Medicaid Eligibility Verification System (MEVS)
   - The MEDIFAX handles an average 450,000 transactions per month.
   - This method for provider verification is provided by the Potomac Group (MEDIFAX) at a cost per transaction to the provider.
   - This service offers a small point-of-service device or personal computer access for some providers who use this method.
3. Interactive Voice Response (IVR) system
   - A telephone is the only equipment needed by providers.
   - IVR verification requests average 62,000 a month.
4. AHCCCS ID Card Swipe
   - Providers access an additional 10,000 verifications a month using this method.

In an effort to continue to improve customer service and meet the increased demand for verifications, AHCCCS is currently developing a WEB-BASED Verification System. The implementation of a WEB-BASED application will offer providers an alternative method for obtaining eligibility and enrollment data without the cost per transaction currently associated with MEDIFAX. In addition, it will provide a method to verify claims data which is not currently available through the existing systems. Following the acquisition and installation of the hardware and completion of software requirements, AHCCCS will conduct a pilot program starting July 1, 2002 with approximately 20 AHCCCS providers. The Administration will carefully monitor and evaluate the success of this new venture.

Health-e-Application

Progress continued this quarter as Arizona strives to become the second state to launch the Health-e-App program, an online application designed to enroll low-income families in AHCCCS programs. Arizona will pilot the program, which is available in both English and Spanish, at 35 sites across the state beginning in May, with an initial two week testing period. The current plan is to have a very limited implementation in June and then conduct a pilot of about seven clinics for several months. Project administrators expect Health-e-App to improve the "accuracy and timeliness" of preparing and submitting applications to eligibility agencies.

All Program Areas

Outreach and Education

A total of 15 presentations were made to community organizations, providers and other groups. Some presentations were specific to one topic such as Medicare Cost Sharing while the majority covered all AHCCCS programs.

The AHCCCS Community Based Outreach Grant ended in February. The purpose of this one year, one million dollar grant, was to provide funding to community based organizations (CBO's) across Arizona to identify families and children who would qualify for AHCCCS. The focus was to identify potentially eligible families and assist them in applying for services utilizing the AHCCCS Universal Application. Seven CBO's received funding to hire 35 outreach positions. These outreach workers submitted 7,042 separate applications with over 14,500 individuals applying for AHCCCS. Approximately 6,000 individuals were made eligible for AHCCCS via this grant.

A meeting was held with the City of Phoenix Education Office and the Creighton School District to assist famililes in obtaining health care. The AHCCCS KidsCare Outreach coordinator for Maricopa County met with Creighton School Benefits' staff to train them on the Universal Application. The coordinator also attended various school district functions to coordinate and provide information to other outreach groups to participate in school district events. Reports will be provided to the City and the school district regarding the number of children enrolled in KidsCare via these outreach efforts.

AHCCCS' Community Relations Manager will continue to coordinate outreach events with the City of Phoenix to distribute information at park and recreation events, including city pools.

The Community Relations' Manager continued to collaborate with several state and local groups. Collaboration includes attending meetings, providing liaison assistance, scheduling presentations, providing materials, providing presentations.

New collaborations were developed with the following entities:

- Arizona School Nurses Association
- Thomas J. Pappas School
- Health Cares
- Grandparents Raising Grandchildren
- State Health Insurance Program

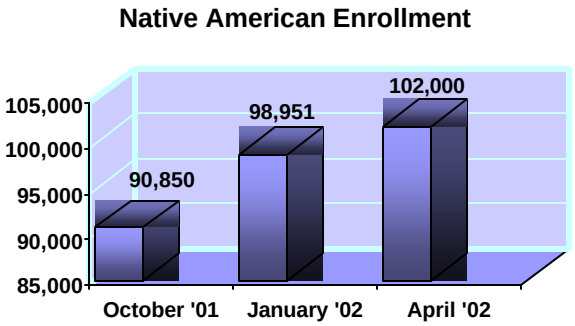
The AHCCCS Community Relations' Manager and Native American Coordinator attended meetings with representatives of the White Mountain Apache Tribe to assist them with their outreach program. The Tribe has received a one million dollar HRSA grant of which a portion will be used on training outreach workers to assist tribal members to apply for AHCCCS, utilizing the Universal Application.

Native American Outreach

The Native American Coordinator continued to work with the Inter Tribal of Arizona/Public Benefit Outreach program for Elders. This program organizes workshops for community volunteers to understand Medicare and AHCCCS in order to find persons who are dually eligible in tribal communities. The volunteers speak the Native language and are well known in their communities

so that Indian Elders will feel comfortable in applying (filling out forms with the volunteer) for programs. Also, the program recently developed a video (in English) that show Indian Elders talking about Medicare and AHCCCS. The Elders talk about how important it is to apply for Medicare, (and for those who qualify) the AHCCCS programs, including acute care services, ALTCS and the Medicare Care Cost sharing programs.

Additionally, each year the Native American Coordinator conducts a presentation to the Indian Health Service (IHS) facilities, to inform them of any changes to AHCCCS. This presentation was given in Kayenta, Gila River, and Sells. The Native American Coordinator plans to go to the Whiteriver and on the Navajo reservation this coming year.



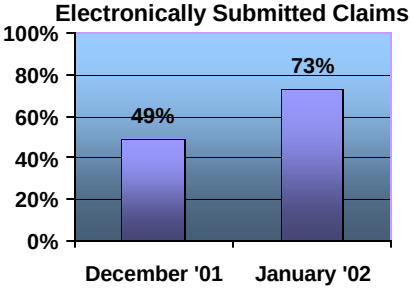
As with the entire AHCCCS membership, Native American enrollment was increased. As of April 2002 there were 102, 000 Native Americans participating in various AHCCCS categories and programs.

Claims Operations/Policy and Training/Provider Registration

During the quarter, the Policy and Training Unit continued to work with the IHS to educate IHS providers on AHCCCS claims policies and processing. Staff attended the Phoenix Area IHS Billing Office Conference to discuss claims issues with IHS business office staff representing several Phoenix Area facilities.

The Provider Registration Unit worked hard at reducing the backlog of new Provider registered and existing provider updates. During this quarter, they reduced the unprocessed inventory from 21 days from receipt to process to 3 days from receipt to process. This was accomplished by implementing batch sorting prior to process and filling open positions within the department.

In the Claims Operations Unit, data entry staff began processing all claims in 7 days or less in December and has been able to maintain this standard throughout this quarter.



At the end of December, the percentage of claims submitted electronically was 49%. At the end of March, 73% of claims were submitted electronically.
The inventory in Adjudication and Research has gone from 1,575 to 529, while the abandonment rate in Claims Customer Service has been reduced to 9.85% in March, from 18.5% in December.

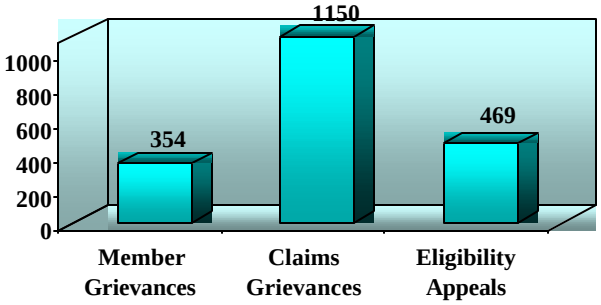
The Information Services Division is working with fewer personnel since the hiring freeze and there is an encouraging amount of teamwork being exhibited as a result.

Member Grievances, Claims Grievances, and Eligibility Appeals

OLA received 1973 cases. Cases fell into one of three types: member grievances, claims grievances, and eligibility appeals. (Chart 1)

(Chart 1)

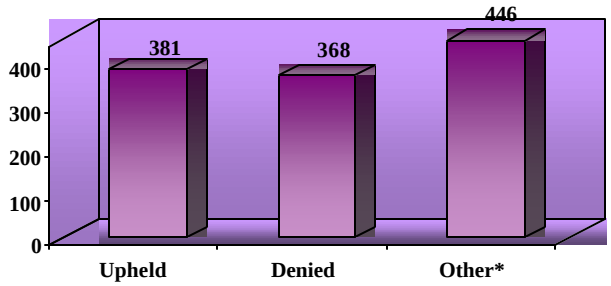
OLA Cases Received
Total 1973



(Chart 2)

**No bases for grievance, Voluntary Withdrawals, etc.*

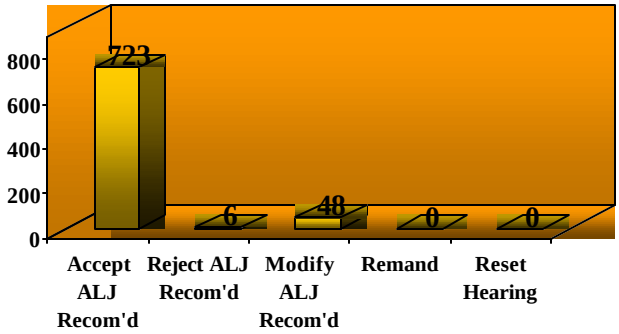
Informal Decisions Issued
Total 1195



Over 71% of the cases filed involved grievances regarding claims. OLA resolved 1195 cases informally, eliminating the need for a formal hearing. (Chart 2)

(Chart 3)

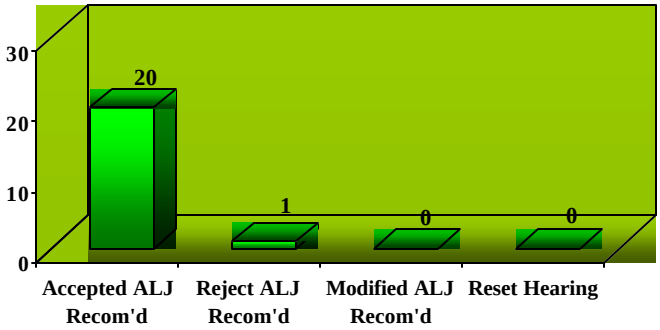
Director's Decisions Issued
Total 777



The Director issued 777 decisions. The majority of these decisions concurred with the Arizona Law Judges' findings. (Chart 3)

(Chart 4)

Final Decisions Issued
Total 21



A total of 21 Final Decisions were issued. (Chart 4)

Fraud and Abuse

In February, the Office of Inspector General (OIG) published and released results of an audit on End Stage Renal Disease Services performed by the AHCCCS Office of Program Integrity (OPI). The OPI audit was conducted as part of the OIG's State Partnership Program. The audit, which identified nearly $3.4 million in potential overpayments to dialysis providers, noted that AHCCCS had taken significant steps to recover overpayments and install more effective claims' edits.

OIG partnership audits are normally conducted in cooperation with independent state audit offices. By contrast, this audit is noteworthy because it represents one of the few partnership efforts undertaken and performed primarily by auditors inside a Medicaid state agency. Before OIG accepts work performed by outside auditors from any agency, it conducts a review of working papers and quality control procedures to determine if the outside agency's work meets generally accepted government auditing standards promulgated by the U.S. Comptroller General. An on-site review by the OIG found that the AHCCCS audit work met these standards.

In September 2001, AHCCCS proposed creation of a new personnel classification for health care fraud investigators. The proposal was designed to create a single classification for investigators, with a broad pay band, that would provide more flexibility and reduce inequities within existing personnel classifications. During the quarter, the Department of Administration, Human Resources office announced its intent to approve the new personnel classification system. Before the new classification system can be implemented, however, detailed job descriptions and pay band ranges need to be finalized and approved.

OPI hosted a quarterly fraud and abuse work group meeting in February focusing on two areas of interest. First, representatives from the Arizona Board of Pharmacy and Mercy Care Plan, an AHCCCS health plan, discussed program safeguards designed to limit abuse and diversion of prescription drugs by AHCCCS members. A draft report on prescription drug fraud and abuse had found that safeguards were in place and effective in controlling this potential problem. Secondly, representatives from the Department of Health Services, Behavioral Health Division discussed an initiative to strengthen and improve efforts to prevent, detect, and report fraud and abuse in the State's behavioral health program. The Division plans to create two positions dedicated to this fraud and abuse control effort.

Encounter Validation Study

The Contract Year 1998/1999 Encounter Data Validation Study final results were distributed to the contractors this quarter. Contractors have 60 days to review the results and issue a challenge. The report to CMS will be sent during the next quarter.

For the Acute and Behavioral Health Programs, the comparison of medical records to encounters began during this quarter for the Contract Year 1999/2000 Encounter Data Validation Study. The ALTCS Encounter Data Validation Pilot Study is looking at available medical record documentation to see if the ALTCS Data Validation process can be improved to do a more thorough validation of AHCCCS services provided to ALTCS members. Currently, ALTCS data validation does not involve medical records.

Operations

Encounter and report transmissions between AHCCCS and contractors continue via File Transfer Protocol (FTP). A newer version of the FTP transmission program, which eliminates partial and full upload problems from the server to the mainframe, was placed in production this quarter. It appears that the newer version eliminated problems of the earlier version. Other refinements are expected to continue to improve data transmissions and outcomes during the next several quarters.

National Meetings

Staff participated in several telephone conference calls regarding Health Insurance Portability and Accountability Act (HIPAA) implementation and implementation issues. In addition, AHCCCS was represented at the 2002 National Council for Prescription Drug Programs Annual Conference to stay abreast of pharmacy-related HIPAA changes. Staff is expected to continue participating in these calls and in meetings scheduled for the next quarter.

Ratesetting

The Physician Fee Schedule was updated for dates of service on and after April 1, 2002. Approximately 95% of the fee schedule rates were maintained at their 2001 levels. Rates were established for new procedure codes and a regular update of injection rates was implemented. The estimated fiscal impact of the changes is negligible.

Information Systems

Health Insurance Portability and Accountability Act (HIPAA)

This 1996 Administrative Simplification Act standardizes the administrative and financial health care transactions in order to reduce the costs and administrative burden of health care. The transactions covered by HIPAA include health care claims, claims payments, enrollment, and eligibility. The provisions apply to all health care plans, including Medicare and state Medicaid agencies, health care clearinghouses, and health care providers that transmit in electronic form any health care information covered by HIPAA. The rules include standards for electronic submission of health care transactions, code sets, identifiers for recipients, providers, and payers of health care services, and security and confidentiality issues around health care data.

Implementing HIPAA will standardize the format of our interface files with external entities, which will be especially helpful when new providers or health plans want to submit data. Providers will use the healthcare data standard format. In addition, HIPAA will define the standard security requirements and enable us to properly safeguard the data entrusted to us as required by our federal business partners.

The "GAP" Analysis has been separated into two parts: transactions and code sets, and security and privacy. The transaction and code set analysis is currently underway with a target completion of May 2002.

The assessment for HIPAA Privacy and Security is scheduled to begin in May 2002. Since AHCCCS has less than one year to comply with the HIPAA Privacy Regulations we plan a re-mediation as "gaps" are identified in this area, working concurrently with the assessment activities.

Hawaii/Arizona PMMIS Alliance (HAPA) Project

Hawaii and Arizona have entered into an agreement to implement the PMMIS for the State of Hawaii Medicaid program through a joint effort of Hawaii Department of Human Services and AHCCCS. Both states expect to benefit from the enhancements that are required to support Hawaii, and together they will share the ongoing maintenance and operation of the system.

During this past quarter, the technical and business teams in Hawaii and Arizona finalized the requirements and detailed design for Hawaii's claims function. Both joint and separate sessions were conducted and a number of design related documents were produced. System coding of the agreed upon design began in late March. The system is scheduled to be fully implemented by April 2003.

AHCCCS Customer Eligibility (ACE)

A DMS eligibility redesign team re-engineered the entire eligibility determination process. Some of the new functionality has already been implemented into manual processes, while other requirements will be implemented together with the AHCCCS Customer Eligibility (ACE) system.

The proposed system has the following objectives:

- Easily integrate new eligibility programs as required (such as, 100% FPL, KidsCare, and Ticket to Work);
- Integrate new concepts such as Universal Application;
- Dramatically improve customer service (substantial reduction in paper, quick entry into services, increased assistance to clients needing verification); and
- Streamline the eligibility process to increase productivity, improve the quality of eligibility determinations and reduce the time it takes to determine eligibility, through easier data entry, reduction in manual processes and utilization of knowledge management principles.

Once the system is developed it will be implemented in one office as a six-month pilot, and then rolled out office-by-office over the next year. The pilot is expected to be operational by October 2002, and the final implementation in March 2004

The ACE development has been realigned into three distinct phases - ALTCS, SSI/MAO and KidsCare. This has been done so that the production system changes specific to these programs can be retrofitted into ACE and fully tested just prior to implementation. The pilot office, which is an ALTCS office, is on target to begin in October 2002. After the six-month pilot operation, the SSI/MAO office will be converted to ACE, followed by the remaining ALTCS offices at a rate of one or two per month. The KidsCare office will be the last one to convert to ACE.

Acute Care Program

Federally Qualified Health Center (FQHC) Prospective Payment System (PPS) Reconciliation

AHCCCS contracted with Myers and Stauffer, LC to develop a PPS rate for each FQHC for Title XIX services provided on or after January 1, 2001. The rate was calculated in accordance with section 1902(a)(15)(c) of the Social Security Act. AHCCCS completed a reconciliation for the period of January 1, 2001 through September 30, 2001 using encounter and reimbursement data submitted by each FQHC. The net amount of the reconciliation was a pay-out to the FQHCs of $2,402,683. The total pay-out represents payments made to those FQHCs whose PPS value per encounter exceeded the total of all monies received from the health plans and AHCCCS for fee-for-service and capitation. Distributions were made in April 2002.

Rate Adjustments

Effective April 1, 2002, the Title XIX Waiver Group (TWG) prospective capitation rates were adjusted based on the actual enrollment mix October 1, 2001 through February 28, 2002. The TWG capitation rates were originally based on estimated enrollment, but have been adjusted to reflect the actual enrollment for the TWG. It was determined that the original enrollment projection for CYE 02 would be met by April 2002, six months early. Using the actual enrollment data resulted in an overall 42% rate decrease.

The TWG Prior Period Coverage (PPC) capitation rates were also adjusted. It was determined that the proportionate risk of the non-Medical Expense Deduction (MED) PPC time period to the prospective time period is more similar to that of Temporary Assistance for Needy Families (TANF) eligibles. The average adult TANF PPC rate is 75% of the prospective rate; therefore, the non-MED rate was reduced to 75% of the prospective rate. This resulted in an overall decrease to the PPC rate of 33%.

Contracts

During the period of January 1, 2002 through March 31, 2002, AHCCCS initiated, awarded or amended the following contracts/agreements:

Issued an RFP for Financial Audit Services with responses due April 15, 2002.

Amended current Behavioral Health agreement with Arizona Department of Health Services to revise Attachment G of the contract, The Behavioral Health Services Guide.

Issued Name Change Amendment for Lifemark Health Plans, the new company name is Evercare Select of Arizona, Inc.

Extended 15 Management Consultant contracts for an additional twelve month.

Issued amendments for Banner Health's two Transplant contracts for rate increases, vendors' signature still pending.

Issued Title XIX Waiver Group capitation rate adjustment amendments to all eight Acute care contractors.

Issued Request for Interest/Information to potential Acute health care plan providers with responses due on April 15, 2002.

Issued new amendment to include pediatric liver transplants under existing contract with Mayo Clinic Scottsdale. This new amendment will allow pediatric cadaveric liver transplants to be provided in Mayo Clinic's Rochester, MN facility.

Extended our IGA with the University of Arizona Rural Health Organization to allow for the completion of the report preparation under the HRSA grant.

During this same period, contracting activities continued on the following contracts, agreements or solicitations:

Canceled the solicitation for Managed Transplant Insurance Services due to budget constraints.

Drafted new Request for Proposals for Consulting services for transplant program. Office of Medical Management is currently finalizing their review and recommendations.

Issued additional amendments were issued for two current Management Consultant contractors for work on continuing HRSA special projects.

Issued new intergovernmental agreement for Comprehensive Medical and Dental Program (CMDP) to Arizona Department of Economic Security (ADES). ADES/CMDP requested an extension of ninety days to facilitate review by their agency prior to signing the new agreement.

Issued a 90 day extension to Comprehensive Medical Dental Program IGA to allow for review of new proposed IGA.

Operational and Financial Review Tool

The Health Plan Operations Unit, in collaboration with other units within Office of Managed Care and the Office of Medical Management, developed and finalized the Operational and Financial Review tool for Contract Year Ending (CYE) 02.

Operational and Financial Reviews

Operational and Financial Reviews of acute care contractors began for CYE 02. During the quarter, the Office of Managed Care, in conjunction with the Office of Medical Management, conducted a review at Health Choice Arizona. The final reports for Arizona Physicians IPA and University Family Care Operational and Financial Reviews for CYE 01 were mailed to the health plans. Operational and Financial Reviews for the remaining health plans will continue throughout the next 3 quarters.

ALTCS Program

ALTCS Operational and Financial Reviews

During this quarter the ALTCS Review Team continued the CYE 02 Operational and Financial Reviews initiated last quarter. Three program contractors were reviewed. Two reviews, which were conducted last quarter, were finalized. Reviews will continue monthly through the next quarter.

New Nursing Facility Acuity Assessment Tool

Effective November 1, 2001, all ALTCS Program Contractors in the Elderly and Physically Disabled program were required to use a Uniform Acuity Assessment Tool to evaluate residents of Skilled Nursing Facilities. All residents were reevaluated by January 31, 2002. The data showed a shift to higher acuities as expected. The data is currently being analyzed for possible adjustments to the Program Contractor capitation rates. The purpose of a uniform tool used by all program contractors is to create consistency in assessment, thus creating uniformity in level of acuity determination.

Annual Enrollment Choice Transition

Since the first Annual Enrollment Choice transition, October 1, 2001, an average of 1,800 members per month have been given the opportunity to switch their program contractor. On average, only 2% of those members have exercised their choice option. All three Program Contractors have designated staff as Transition Coordinators to ensure uninterrupted services to those members who chose to change. There have been no reported incidents of service delivery problems. The Annual Enrollment Choice process will continue on a monthly basis for Maricopa County members.

Behavioral Health

Integration of Care Committee

AHCCCS' Office of Managed Care/Behavioral Health Unit (OMC/BHU), in collaboration with the Office of Medical Management (OMM), convened a meeting February 8, 2002, with representatives of the Acute Care Health Plans and Arizona Department of Human Services/Behavioral Health Services (ADHS/BHS) to identify opportunities for collaborative problem resolution and strategic performance improvement initiatives in the area of coordination of care between the acute health plans and providers and the carve-out behavioral health contractor and providers. The agenda included:

- An overview of the history and previous work of the committee;
- Decisions regarding the structure, leadership and function of the current committee;
- Updates on recent and upcoming conferences on coordination of care; and,
- Establishing priorities for committee focus.

The group identified the following major areas as priorities for collaboration:

- Data sharing;
- Review and evaluation of the psychotropic medication initiative; and,
- Developing guidelines for management of complex medical and behavioral health problems for dually served members.

Subcommittees were selected to address each of the priority areas and report back to the committee of the whole. Subcommittee meetings addressing policy guidelines and the psychotropic medication initiatives are scheduled for initial meetings in April 2002.

ALTCS / Behavioral Health Ad Hoc Committee

AHCCCS' OMC/BHU staff, in collaboration with AHCCCS staff from the OMM, and Division of Member Services, convened an ad hoc committee to study the profiles and patterns of referrals of members transferring from the acute care system, and receiving behavioral health services through the ADHS/DBHS (the behavioral health carve-out contractor), to the ALTCS. The goals of the ad hoc committee are to:

- Review the profiles of ALTCS members who present with a significant history of behavioral health problems, services, and needs, in addition to medical management needs;
- Work collaboratively with and provide technical assistance and support to the ALTCS Program Contractors in identifying contractor challenges in managing these members, training needs and service network needs and gaps; and,
- Continue to facilitate development of enhanced processes for the transition of members from the acute to the ALTCS system of care.

The committee will facilitate the first of several meetings with the program contractors to provide information obtained from initial fact finding and to gather additional information from the contractors.

AHCCCS Eligibility for Members Discharged from the Arizona State Hospital

The AHCCCS OMC/BHU, in collaboration with AHCCCS Division of Member Services, acute health plan behavioral health coordinators, and staff of the Arizona State Hospital, have worked with the Social Security Administration and the Department of Economic Security to develop streamlined eligibility processes. This ensures that those patients discharged from the Arizona State Hospital who are eligible for AHCCCS services, are enrolled immediately upon discharge, and have access to medically necessary covered medical and behavioral health services.

Transition from Arizona State Hospital to Arizona Long Term Care System

AHCCCS OMC/BHU and ALTCS Units have continued to work with the Long Term Care Contractors and the Arizona State Hospital to develop appropriate discharge plans and community placement options for discharge-ready patients.

Operational and Financial Reviews of Contractors

AHCCCS' Office of Managed Care/Behavioral Health Unit (OMC/BHU) participated in operational and financial reviews (OFRs) of the following Contractors scheduled during the reporting period:

- Cochise Health System,
- Health Choice Arizona, and
- Yavapai County Long Term Care.

The behavioral health portion of the OFRs utilized review tools based on contract standards that were developed for both Acute and Arizona Long Term Care System (ALTCS) Contractors. The review tool for Acute Contractors included the following behavioral health related content areas:

- Early and Periodic Screening, Diagnosis and Treatment (EPSDT);
- Behavioral health policies and procedures;
- Coordination of care and communication with members (e.g., member handbooks); and
- Primary Care Providers' medical management of behavioral health disorders.

The review tool for ALTCS Contracts included:

- Adequacy of a provider network,
- EPSDT, and
- Quality of care.

OMC/BHU will continue to participate in the OFR process of AHCCCS' Contractors through the next two quarters of 2002.

Integration of Care Conference/Training Series

Staff from OMC/BHU attended a series of three conferences and forums on integration of behavioral and medical care. The series included:

- Integration models for community health centers,
- Integration model training for commercial and public sector pcp practices, and
- A policy forum addressing challenges and strategies for enhancing integration of care.

Member Identification Cards

Regional Behavioral Health Authority (RHBA) member services phone numbers were added to AHCCCS member identification cards to facilitate access to behavioral health and substance abuse information and services. The toll-free number of the RBHA that is contracted to provide services in the member's Geographic Service Area appears on the front of the card and will allow members to speak directly to RBHA member service or directly to crisis providers.